DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 8 - 1 5
2. STATE: Alaska
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OCT 5 1998

4. PROPOSED EFFECTIVE DATE
July 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

FILE COPY

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-447.252 and 42CFR447.256-447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 1998 $ 0
b. FFY 1999 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A

10. SUBJECT OF AMENDMENT:
Revision of Disproportionate Share calculation

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bob LeBon

14. TITLE:
Director, Division of Medical Assistance

15. DATE SUBMITTED:
September 29, 1998

16. RETURN TO:
Division of Medical Assistance
PO Box 110660
Juneau, AK 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT 5 1998

18. DATE APPROVED: MAY 29 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 1998

20. SIGNATURE OF REGIONAL OFFICIAL: Teresa Trimble

21. TYPED NAME: Teresa L. TRIMBLE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID

23. REMARKS:

POSTMARKED: 9/30 (DATE)

Juneau

FORM HCFA-179 (07-92)

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STATE PLAN FOR MEDICAID PROVIDER RE[illegible]SEMENT

INPATIENT HOSPITAL

Inpatient hospital services are paid for Medicaid recipients b[illegible]s of rates determined in accordance with the following principles, methods and standa[illegible]h comply with 42 CFR 447.250 through 477.299.

I Introduction:

Rate setting principles and methods are contained [illegible]ska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Adm[illegible]e Code 7 AAC 43.

Data sources used by the Medicaid Rate Advisory Cor[illegible]n and the Department of Health and Social Services are the following:

1. Medicare Cost Reports for the facility's' fiscal y[illegible]ng 24 months before the beginning of the facility's prospective payment y[illegible]

2. Budgeted capital costs, submitted by the facility a[illegible]ewed and adjusted by the Department as appropriate in accordance with [illegible]II, for the rate year on capital projects or acquisitions which are placed [illegible]e after the beginning of the base year and before the end of the rate year. [illegible]which an approved CON (Certificate of Need) has been obtained.

3. Operating budgets, as applicable, submitted by ne[illegible]caid providers.

4. Year end reports which contain historical fina[illegible]d statistical information submitted by facility's for past rate setting years.

5. Utilization and payment history provided by the [illegible] of Medical Assistance.

II Allowable Costs:

Allowable costs are documented costs that are ordinary a[illegible]ssary in the delivery of a cost effective service. Allowable costs are those wh[illegible]tly relate to Title XIX program recipients. They are costs which must be [illegible]d by an efficiently and economically operated provider. Costs would include [illegible]cessary to conform with the state and federal laws, regulations, and quality and sa[illegible]dards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

* return on investment is not an allowable cost for any facility.

* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:
  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as a part of a facility's accreditation process.

* physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

* medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

* costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

Teaching costs are not an integral part of the rate setting methodology. No facility in the state has a teaching program.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described

within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III Inflation Adjustments:

Allowable costs are determined by adjusting base year data. Base year data will be the allowable operating costs excluding capital in the facility's fiscal year ending 24 months before the prospective rate year. The allowable base year costs are adjusted for inflation. Inflation is calculated annually using projected inflation indices developed based on data available in May prior to the facility's fiscal year beginning.

The inflation index is developed using national and regional inflation projections from Data Resources, Incorporated and other available sources. Inflation was projected on a compound rate over a two year period of time. A review was also made of regional economic trends which was incorporated into the inflation projections. Inflation forecasts were developed based on anticipated changes in inflation using a HCFA type market basket.

IV Determination of Payment Rates:

The prospective payment rates for inpatient hospital services rendered to Medicaid recipients is a percentage of billed charges. Payments are made for allowable services for Medicaid including daily hospital and ancillary services. The percentage of payment is based on the allowable costs as a percentage of total charges.

The payment system for inpatient hospital services includes not only a percentage of billed charges paid but also a maximum aggregate charge per adjusted admission that will be paid. The charge per adjusted admission is the cap or maximum allowable aggregate average charge throughout the facility's fiscal year. An adjusted admission factors in outpatient services into the admissions. This allows a measurement of total revenue billed per unit of service. The formula for calculating adjusted admissions is total

Medicaid revenue divided by inpatient Medicaid revenue times the number of Medicaid admissions. This calculation yields a "grossed up" admission. The percentage of charges represents allowable costs relative to billed charges.

V Rate Calculation:

The determination of the percentage of payment is based on a base year comparison of Medicaid allowable costs components to billed charges (patient service revenue) for the facility. The base year would be the facility's fiscal year ending 24 months before the prospective rate year. For example, if a facility's prospective rate year begins January 1, 1997 the base year would be January 1 through December 31, 1994. The percentage of charges for Medicaid services may not exceed 100% of charges determined under the regular rate setting methodology. The 100% maximum is without regard to any Disproportionate Share add-on percentage.

To determine the allowable rate of increase, the base year operating expenses less capital are inflated by the indices described in the inflation section. Capital costs are added into the rate structure as total base year capital costs, plus Department determined capital costs on CON approved capital additions which are placed in service after the beginning of the base year and before the end of the rate year. Principal payments on long term debt are not included in allowable costs. CON capital must have already received an approved CON. A CON (Certificate of Need) is required for certain expenditures of $1,000,000 or more. Situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds.

Once the allowable operating expenses for the payment year have been determined, an allowable percentage increase or decrease in revenue per adjusted admission is calculated. This allowable increase or decrease is calculated comparing the allowable operating expenses in the base to the new allowable operating expenses in the budget year. This percentage change is then applied to the average rate per adjusted admission calculated in the base year. An example would be if base year operating costs were allowed to increase 7.8% for inflation plus an additional 1% due to new CON capital acquisitions and related capital costs for a total of 8.8% rate increase in allowable costs over the base year. The cap is then calculated assuming the average charge over the base year can increase 8.8% before adjustments are made by the state at year end conformance.

Further adjustments are described in the base year adjustment subsection.

BASE YEAR ADJUSTMENT

The reasonableness test is applied to not allow the rolling base year to unduly reward or penalize the providers. For example, the allowable costs per adjusted admission (base) are subjected to a test of reasonableness where the 1994 base plus the 1995 and 1996 inflation are compared to the 1996 approved rate. For providers who maintain costs at a level less than the base plus inflation, the provider will be allowed to retain 50% of the savings up to 5%. For providers who have not maintained costs within the approved 1996 rate when inflation is added to the base, the provider will be able to keep only 50% of the difference not to exceed 5%.

These methods and standards are revised to provide for a rebasing of costs incorporated into the rate calculation process for facilities with prospective fiscal year beginning January 1, 1997 through December 1, 1997. Base year and approved year financial and statistical information will be identical in rate calculations for facilities with fiscal years beginning during that time.

Allowable costs per adjusted admission less capital as calculated in the base year are adjusted to reflect inflation between 1994 and 1996. This cost per adjusted admission is compared to the approved cost per adjusted admission in the 1996 year. The following adjustments are made:

1. If the base year costs exceed the approved costs, the allowable costs for 1997 will be limited to the 1996 approved costs plus the inflation between 1996 and 1997 plus 50% of the difference between the allowable costs of the two years limited to 5% of the costs in the 1994 base year.

2. If the base year non-capital costs are less than the approved non-capital costs, the non-capital costs will be calculated using the 1994 allowable base costs plus inflation identified in the inflation section plus 50% of the difference between the two years limited to 5% of the costs in the 1994 base year.

3. Adjustments in 1 and 2 will be reflected in a reduction of or an addition to the percentage of charges.

Inflation is added to the non-capital costs. Capital costs in the rate year are facility base year capital costs, plus Department determined capital costs on CON approved capital additions which are placed in service after the beginning of the base year and before the end of the rate year. CON capital is allocated to the applicable cost centers based on relevant CON and other documentation. The capital is added to the allowable non-capital costs. A 1997 example of the rate setting methodology is as follows:

	1994 BASE		1996 APPROVED	
	PERCENT	**AMOUNT**	**PERCENT**	**AMOUNT**
	100.00%	$4,333.85	100.00%	$5,463.09
Net Operating Expenses Per Adjusted Admission		$4,333.85		$5,463.09
Capital				
Capital	4.01%	$ 173.61	3.75%	$ 205.05
		$ 173.61		$ 205.05
Total		$4,160.24		$5,258.04
Inflation on Base Year (2 years)	4.80%	$ 199.69		//////////////
		$4,359.93		$5,258.04
Difference (Base-Current)	($898.11)			
50% of Difference	$449.06			
5% of Base	$208.01			
If Difference is Negative:				
Add Inflation to Base (3 years)	6.60%	$ 274.58		
Add lesser of 50% or 5%		$ 208.01		
If Difference is Positive per 7 AAC 43.685(f)(1):				
Add Inflation to Approved (1 yr)	1.80%			$ 0.00
Add lesser of 50% or 5%				$ 0.00
Program Year Allowable Expenses		$4,642.83		$ 0.00
Base Year Allowable Capital				
Capital	$173.61			
CON Capital	0.00			
	$173.61	$ 173.61		$ 0.00
Budget Year Allowable per Adjusted Admission		$4,816.44		$ 0.00
Adjustment in accordance with 7 AAC 43.685(f)(2)		4.80%		

		BASE YEAR		PROSPECTIVE YEAR	
Base Operating Expenses			$2,030,023		$2,077,316
Capital		(81,321)		81,321	
Certificate of Need Capital		N/A		0	
Total Capital			(81,321)		81,321
SUBTOTAL			$1,948,702		$2,158,637
INFLATION (3 years)	6.60%		128,614		
TOTAL			$2,077,316		$2,158,637
Allowable Cost Basis			$2,030,023		$2,158,637
Rate Change					6.34%
Maximum Aggregate Average Charge per adjusted admission					$3,194.27
Allowable Expenses per adjusted admission					$4,816.44
Percentage of Charges					144.27%
Adjustment in accordance with 7 AAC 43.685(f)(2)					4.80%
Year End Adjustment in accordance with 7 AAC 43.691					0.00%
Percentage of Charges					149.07%
ALLOWABLE PERCENTAGE OF CHARGES (7 AAC 43.685(c))					100.00%

The example identifies Allowable Revenue per adjusted admission and Allowable Expenses per adjusted admission for the prospective payment year. The percentage represents the percentage of charges that is approved for the prospective payment year. Since the calculation results in a percentage of charges greater than 100%, the allowable percentage is set at 100%.

The section removes capital costs in the allowable expenses. Non-capital expenses are inflated. Base year actual capital costs and approved CON capital costs are added back to the inflated non-capital costs for total allowable costs in the prospective payment year.

To compare the base year costs excluding capital to the prospective payment year costs, three year's inflation is added (6.6%) to bring base year costs excluding capital to the prospective payment year level. The percentage increase between base year costs and prospective payment year costs is calculated and the resulting percentage is applied to the base year Revenue per adjusted admission to get the Allowable Revenue per adjusted admission for the prospective payment year.

Year End Conformance

Year end conformance will be reviewed comparing the actual charges billed against the approved Maximum Aggregate Average charge per adjusted admission. If the actual charges per adjusted admission exceed the allowable Maximum Aggregate Charges per adjusted admission as approved, the percentage of charges will be adjusted downward in the facility's prospective fiscal year. The percentage adjustment will be calculated as the product expressed as a percentage of the actual net overpayment to the facility divided by the facility's gross Medicaid charges. The net overpayment is the sum of the facility's actual charges per adjusted admission less the facility's approved maximum Aggregate Average Allowable charge per adjusted admission multiplied by the facility's Medicaid adjusted admissions which product is further multiplied by the facility's approved percentage of charges for the Year End Conformance year.

Sample year end conformance calculation:

7 AAC 43.691(a)(1)	
Actual charges per adjusted admission	$4,408.36
Approved maximum charges per adjusted admission	$3,003.95
Difference	$1,404.41
1995 Medicaid adjusted admissions	45.09
Overpayment (gross)	$63,320.76
Paid percent of charges	100.00%
Overpayment (net)	$63,321
Gross Medicaid charges	$1,135,440
1995 YEC Adjustment	5.58%

(Note: A positive reduces a facility's Prospective Rate.)

The facility has the option of making a payment to Medicaid to reimburse calculated base year overpayments (net) rather than having an adjustment made to their prospective payment rate.

All or part of any adjustment for year end conformance may be waived for a facility. A waiver may not be below a percentage calculated by dividing the net overpayment by the gross Medicaid charges in the year end conformance year. The net overpayment is the difference between actual Medicaid average payment per adjusted admission and the actual allowable Medicaid costs per adjusted admission.

Sample waiver calculation:

7 AAC 43.691(d) - Waiver Limitation	
Actual charge per adjusted admission - base year	$4,408.36
Paid percent of charges - base year	100.00%
Actual average payment per adjusted admission - base year	$4,408.36
Allowable costs per adjusted admission - base year	$4,333.85
Difference	$ 74.51
1995 Medicaid adjusted admissions	45.09
	$3,359.66
Gross Medicaid charges	$1,135,440
1995 YEC waiver limit	0.30%

Examples of situations warranting consideration of a waiver include:

- The average level of acuity of patients in the facility has increased between the base year and the year end conformance year. Basing the year end conformance year rate on a base year in which the facility was taking care of patients with fewer patient care needs can be found to be a situation warranting a waiver.

- New approved services have been added by the facility which increase year end conformance year costs per adjusted admission. Basing the year end conformance year rate on a base year in which the facility was not providing the new services can be found to be a situation necessitating a waiver.

Processing procedures and approval criteria

- The facility must prove to the department's satisfaction that a waiver is necessary.

- The department may approve a waiver request if it finds that:

    - The facility has taken effective measures to control costs in response to the situation upon which the waiver request is based;

    - The waiver request does not contradict a prior action of the department as to an element of the facility's rate as the action relates to the application of the established inflation factor, the rate methodology, or the definition of allowable costs.

- The waiver request would result in payment for only allowable cost of services authorized by the department under State or Federal laws, or both if applicable, or under regulations.

- The situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

State Facility

The annual rate of increase in a state inpatient hospital facility rate is limited to the applicable inflation factor per Section III above.

Payment Rates for New Facilities

If a new facility is licensed, the rates for the first three fiscal years will be calculated as follows:

For acute care hospital and specialty hospitals, the percentage of charges will be set at the statewide weighted average of percentage of charges and allowable maximum aggregate average charges of acute care hospitals and specialty hospitals for the most recent 12 months of permanent rates set for acute care facilities. The weighted average percentage of charges is weighted based on total facility patient days. The weighted average maximum aggregate average charge is weighted based on Medicaid patient days.

For inpatient psychiatric hospitals, the percentage of charges will be set at the statewide weighted average of percentage of charges and allowable maximum aggregate average charges of non-state inpatient psychiatric hospitals for the most recent 12 months of permanent rates set for inpatient psychiatric facilities.

Optional Payment Rate Methodology for Small Facilities

Facilities that received combined inpatient hospital, outpatient hospital, and long term care Medicaid payments, including disproportionate share adjustments, of no more than $2,750,000 during the facility's fiscal year that ended during the period July 1, 1995 to June 30, 1996 may make an election for Medicaid reimbursement based on the Optional Payment Rate Methodology for Small Facilities. The election requires the acute care hospital to be reimbursed under this method from the beginning of the facility's fiscal year that begins during the period January 1, 1998 to December 31, 1998, until the last day of the facility's fiscal year that ends during the period July 1, 2001 and June 30, 2002